10. Can I fax my claim form?

Yes, we can accept faxes at **508-853-2867**; we also ask that the original be sent via mail. Our fax number appears in the upper left-hand corner of our Claim Forms for your convenience.

11. What if I don't agree with the claim decision?

You may appeal our decision by writing to us at:

Trustmark Insurance Company
100 North Parkway
Suite 200
Worcester, MA 01605

Please note this brochure is meant as a guide and is not part of your policy. All benefits are based on the provisions of your policy/certificate and any riders attached thereto. Benefits, definitions, exclusions and limitations may vary by state.

Trustmark
Voluntary Benefit Solutions®

Underwritten by Trustmark Insurance Company

400 Field Drive • Lake Forest, IL 60045
www.trustmarksolutions.com

P609-16 (3-10)

What to Expect

When You Have A Claim

Frequently asked questions about the accident claims process

1. How do I file a claim?

Please complete the Initial Claim form. If you need one, please contact us at (800) 918-8877 or go to our website at **www.trustmarkins.com/customersolutions**. The form consists of a few sections which must be completed by you. If you are submitting a disability claim, both your doctor and your employer must also complete the form.

Please also submit medical information/invoices such as:

- Emergency Room Bills
- Hospital Bills
- Post Operative Reports, etc.

You must complete the **Claimant Statement** and **Disclosure Authorization** for us to evaluate your claim.

If you are filing for disability:
Your physician for your disability must complete the **Attending Physician Statement** to provide information regarding your disability.

Your employer must complete the **Employer Statement** to verify employment. If you are self-employed, you should complete it with as much detail as possible.

2. How do I collect my Wellness Benefit?

If your policy includes a Wellness Benefit, to collect it all we need is a copy of the bill which contains your name, the name and address of the facility where the test was done, the type of procedure performed and the date of the procedure. Prescriptions are not covered under your Wellness Benefit.

You may either mail your screening evidence to: Trustmark Insurance Company, 100 North Parkway, Suite 200, Worcester, MA 01605, or Fax to: 1-508-853-2867.

3. Who will review my claim?

When we receive your claim, we will assign it to a Claim Representative. Our representative will provide you with timely service and the highest level of customer service.

4. When will I receive benefits?

Your policy is designed to provide benefits soon after we receive adequate proof of loss.

5. What is expected of me?

We ask that you provide us with a completed claim form and all bills and medical information pertaining to your claim.

6. Are sicknesses covered by my Accident policy?

No. Trustmark Accident insurance provides benefits for accidents and injuries only.

7. Do I have to fill out a claim form every month?

If your policy includes a Disability Benefit, to collect it you must submit a Continuance Claim form monthly as your proof of your ongoing disability. This form consists of your claimant statement and authorization, as well as one from your physician. The form should be returned to us as close to the end of each 30-day period as possible, or sooner if you are released to return to work.

8. Should I continue to pay my premiums when I have a claim?

Yes, you should continue to pay your premiums when you make a claim. This will keep your policy current while we review your claim.

9. My policy is new. Will this delay my claim?

No. Accident benefits begin on the effective date of your policy. If your policy includes a Wellness Benefit, there is a 60-day Waiting Period after the effective date before a service is eligible for reimbursement.

TRUSTMARK INSURANCE COMPANY

ACCIDENT CLAIM FORM

100 NORTH PARKWAY, SUITE 200 • WORCESTER, MA 01605
1-800-918-8877 • FAX 1-508-853-2867
www.trustmarkins.com/customersolutions

This form must be completed by the attending physician and the policy owner and be returned to us for consideration of benefits. If you are claiming under the Accident Disability Benefit, the Employer section must be completed. All questions on this form must be answered in full. Incomplete or illegible answers may result in delay of benefit consideration. Please keep a copy of this form and any attachments for your records.

The policy owner is responsible for completion of all portions of this form without expense to Trustmark Insurance Company.

FRAUD NOTICE: Any person who knowingly and with intent to defraud an insurer files an application or a statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

INSTRUCTIONS:

Section A & B: These sections must be completed by you, the policy owner.

Section C: This section must be completed by the physician who is treating you for this disability/accident.

Section D: This section must be completed by your employer if you are filing a claim for the Accident Disability Benefit.

State Required Fraud Language: Attached for your information.

Disclosure Authorization: You must sign and date this form. Provide a copy of the signed and dated form to your attending physician.

Please enclose any additional information that you feel will assist Trustmark in evaluating this claim.

SECTION A:

Policy/Certificate #: _____ Policy Owner Name: _____

Patient's Name: _____ DOB: _____

Relationship to Policy Owner: ☐ Spouse ☐ Child ☐ Self ☐ Other

Policy Owner Address: _____
Street City State ZIP Code

Policy Owner Home Phone: _____ Policy Owner Work Phone: _____

Policy Owner Date of Birth: _____ Policy Owner Social Security #: _____

SECTION B: POLICY OWNER'S STATEMENT

Please complete below and attach itemized copies of any related bills, including doctor, emergency room, hospital and motor vehicle incident/accident report. Bills should include diagnosis information from your medical provider.

Date of accident: _____ Date of first treatment for the accident: _____

Please provide a description of where the accident occurred and what happened to you.

_____

_____

_____

Primary Care Physician: _____ Phone No. of Primary Care Physician: _____

_____
Street City State Zip Code

Were you confined to a hospital? ☐ Yes ☐ No If yes, please provide the following:

Name of Hospital: _____ Phone No. of Hospital: _____

_____
Street City State Zip Code

Dates of Hospitalization: _____

The statements made by me on this claim are true and complete. I have read and understand the fraud notices contained in this claim form.

Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Signature of Claimant _____ Please Print Name _____

I signed on behalf of the claimant, as _____ (relationship). **If Power of Attorney, Guardian or Conservator, please attach a copy of the document granting authority.**

Date Signed _____

SECTION C: ATTENDING PHYSICIAN STATEMENT

ICD -9 Code: _____ Diagnosis: _____

Was this condition the result of an accident? ☐ Yes ☐ No If yes, was the accident work related? ☐ Yes ☐ No

Was the patient hospital confined? ☐ Yes ☐ No If yes, dates of confinement: _____

During confinement was the patient in intensive care or coronary care unit? ☐ Yes ☐ No If so, dates of confinement: _____

Hospital Name: _____ Hospital Address: _____

If the condition was a fracture, was it an avulsion/chip fracture? ☐ Yes ☐ No

If the condition was a fracture or dislocation, was it an: ☐ Open Injury ☐ Closed Injury

If the condition involved laceration(s), what is the length of each laceration? _____

If the condition was a burn, please indicate: ☐ Second Degree: _____ Percentage of Body Surface

☐ Third Degree: _____ Square Inches of Body Surface

Did burn require skin grafting? ☐ Yes ☐ No

As a result of this accident, did patient sustain a concussion? ☐ Yes ☐ No

If yes, date diagnosis made and the medical imaging procedure used _____

Did the patient suffer from any broken teeth requiring crowns or extractions? ☐ Yes ☐ No

Did the patient undergo any surgery? ☐ Yes ☐ No If so, please provide a copy of the operative report.

Do you consider the patient to be completely unable to work from the date of the accident? ☐ Yes ☐ No

If yes, how long do you believe the patient should remain out of work? _____

Activities of daily living mean: basic human functional abilities for the patient to remain independent. These include: bathing, continence, dressing, eating, toileting or transferring.

Is the patient considered to be house confined or unable to perform two or more activities of daily living? ☐ Yes ☐ No

If yes, dates: From _____ To _____

(This information will be used in accordance with state regulations and policy provisions.)

Was this patient referred to you from another physician? ☐ Yes ☐ No If yes, please provide the following:

Name of Referring Physician: _____ Telephone Number: _____

_____

Street City State Zip Code

_____ _____ _____ _____

Physician's name (please print) Degree Specialty Telephone No.

_____

Street City State Zip Code

_____ _____ _____

Signature of the Doctor Date Fax No.

INTERNET

SECTION D: EMPLOYER STATEMENT

Name of Employer: _____ Telephone number: _____

_____

Street City State Zip Code

Employee's Title: _____

What are the employee's job duties? (If possible please provide job description):

_____

Average Hours Worked Weekly: _____ Annual Salary: _____ Last Date Worked: _____

Dates this employee has been unable to work: From _____ To _____

Date the employee returned to work _____

Did the accident occur while working for wage/profit? ☐ Yes ☐ No

Has the employee been terminated? ☐ Yes ☐ No If yes, when: _____

Has employee filed a workman's compensation claim? ☐ Yes ☐ No If yes, please provide the following:

Name of workman's compensation carrier: _____ Telephone #: _____

_____

Street City State Zip Code

Print Name of person completing form: _____ Title: _____

Signature of Employer: _____ Date _____

State Required Fraud Warnings

New Hampshire Residents: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud.

Arizona Residents - For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California Residents - For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado Residents - It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purposes of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Kansas and Oregon Residents: Any person who knowingly, and with the intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud, which may be a crime.

Kentucky Residents - A person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Arkansas, Louisiana and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota Residents - A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

FRAUD WARNING FOR WASHINGTON, MAINE, TENNESSEE AND VIRGINIA RESIDENTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

FRAUD WARNING FOR PENNSYLVANIA RESIDENTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES ANY APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

New Jersey Residents - Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Fraud Warning for Oklahoma, as well as for the residents of all states not specifically listed WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Fraud Warning for Alaska Residents - A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Fraud Warning for District of Columbia Residents - WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Fraud Warning for New Mexico Residents - ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Fraud Warning for Ohio Residents - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Fraud Warning for Texas Residents - Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Fraud Warning for Maryland Residents - Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

DISCLOSURE AUTHORIZATION

Insured's name (Please print):_____

I AUTHORIZE any doctor, hospital, clinic, other medical facility or provider of health care, insurer or reinsurer, consumer reporting agency, insurance support organization, insurance agent, employer, financial institution, the Social Security Administration, the Internal Revenue Service, the Veterans Administration or any other organization or person having any knowledge of me or my health to give to Trustmark Insurance Company and affiliates or its employee and agents, or any other consumer reporting agency any information as to cause, treatment, diagnoses, prognoses, consultations, examinations, tests or prescriptions with respect to my physical or mental condition or information concerning me, my occupation, employment history, earnings or finances or information otherwise needed to determine policy claim benefits due me. This may include, but is not limited to, HIV Infection, any disorder of the immune system including Acquired Immune Deficiency Syndrome (AIDS), driving records, mental illness, or use of alcohol or drugs.

I further AUTHORIZE the Social Security Adm. to release information or records about me to Trustmark Insurance Company or authorized representatives. This information is to be released in order to properly adjudicate my claim or continue my eligibility for benefits. Please release detailed earnings for up to the last ten years and/or summary record of total earnings and/or information from master benefit records regarding award, denial or continuing benefits.

This authorization may be revoked by me. Any such revocation must be in writing, must be signed and dated by me and must be forwarded directly to the Trustmark Insurance Company. I AGREE the information obtained with this Authorization may be used by Trustmark Insurance Company and affiliates to determine policy claim benefits with respect to the Insured. A photocopy of this authorization is as valid as the original and I may request a copy. This authorization will be in force for the term of coverage of the policy up to 12 months from the date shown below. I understand that if I revoke or fail to sign this authorization or alter its content it may affect the handling of my claim including denial of benefits under my policy.

I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

I AUTHORIZE Trustmark Insurance Company and affiliates to report to ICS, any dates of past or present claims filed by me.

Residents of MT – You are entitled to request a record of any subsequent disclosure of information.

RESIDENTS OF NM – Revocation of the authorization must be made within 10 days after its receipt by Trustmark Insurance Company; this applies only to confidential abuse information.

Residents of Florida – Any person who knowing and with intent to injury, defraud or deceive any insurance company files a statement of claim or application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Resident of NY – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim or each such violation.

Date: _____ Signature: _____

Date of Birth_____/_____/_____ Relationship if other than insured:_____